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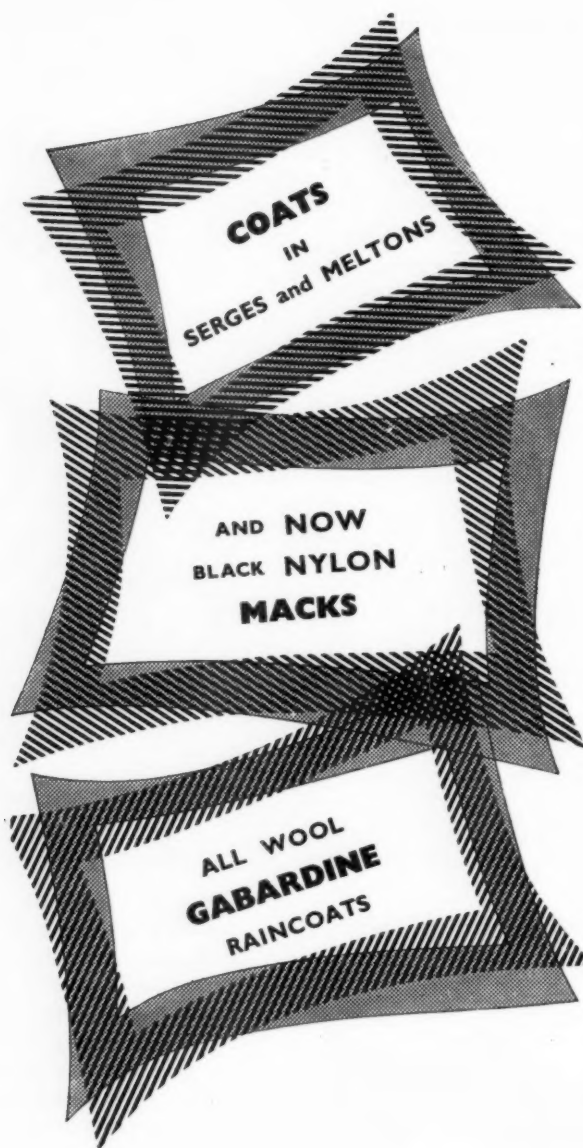
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District Nursing

APRIL 1958 · No. 1 · Vol. 1

CONTENTS

ROYAL WELCOME

A message from Her Royal Highness The Princess Alice,
President of the Queen's Institute

THE BIRTH OF "DISTRICT NURSING"

How the journal came into being

TEN YEARS OF HEALTH PROGRESS

by Dr. H. Van Zile Hyde

THE LINK TO HEALTH

Beginning a series of articles on branches of the National
Health Service

No. 1 by a General Practitioner

THE QUALITIES OF LEADERSHIP

by Sir John Hunt

DOMICILIARY MIDWIFERY TODAY

by Ethel M. Bryant

STARTING A DISTRICT NURSING SERVICE IN JAMAICA

by Rosalie Hunt

HEALTH VISITING IN THE FUTURE

by H. H. Conner

REPORT FROM NORWAY

An account of a visit to study tuberculosis

ON THE HEALTH FRONT

News of the latest developments in nursing and welfare

THIS SEASON'S GARDENS

DISTRICT NURSE TRAINING

by the Queen's Institute Education Officer

QUEEN'S NURSES

Association; appointments, etc.

Editorial

WELCOME to District Nursing.

Welcome, the former subscribers of *Queen's Nurses' Magazine*, and the new wider readership in the public health nursing, medical and welfare services, that **District Nursing** will reach. An appreciative welcome also to our advertisers whose generous support has enabled us to aim beyond the confines of a simple domestic magazine.

As the journal of the Queen's Institute of District Nursing, we shall report Institute activities at home and overseas; but our objectives go much further than a purely domestic interest.

Although district nursing is a specialised field, we believe that it should not be considered as an isolated one. It is a part of the national health service which needs to function as an integrated whole if patients are to receive full benefit of a comprehensive, continuous treatment as they pass, say, from general practitioner to hospital, to district nurse and general practitioner again. We believe that to ensure perfect co-operation all branches of nursing, medicine, and welfare should be linked by an understanding of one another's responsibilities, problems, and methods.

Our policy is to help forge those links and foster mutual understanding, especially in the liaison of district nurse, domiciliary midwife, and health visitor, with other sections of the national health service unit.

We are a non profit-making company. By encouraging friends and associates to become subscribers readers can expect better value in return, for all surplus of income over expenditure will be devoted to improving the magazine. Readers in sympathy with our aims can assist, too, by mentioning **District Nursing** when replying to advertisers, whose advertisements are accepted only after professional approval by a medical and nursing committee, and therefore merit support with confidence.

We do not regard ourselves in competition with our colleagues of the nursing and medical press, but as complementary to them, filling a natural gap in this field, and fulfilling also, we hope, a much-needed want.

The Birth of 'District Nursing'

by A. H. M. WEDDERBURN

Chairman of the Board of Directors

SINCE the beginning of this century, the Queen's Nurses' Magazine has been published by Queen's Nurses for Queen's Nurses, but since the end of the war the magazine, like many others, has suffered from the tremendous rise in printing costs. Eventually, the voluntary editor, Miss M. B. Dixon, and her committee, agreed that it was no longer possible for them to produce the magazine without outside help, and they decided to approach the Queen's Institute for financial aid.

During the past decade of struggle for the Magazine, many changes had come about in the district nursing world. The National Health Service Act which came into force in 1948 changed the administration of the service in many parts of the country, and brought local health authorities into the picture: nursing techniques were being improved daily; and we saw the gradual building up of the public health team consisting of general practitioner, district nurse, midwife, health visitor, almoner, and others. The Queen's Institute has always been concerned with the need to integrate public health workers into a team, for the benefit of the patient.

For some time before the approach from the Queen's Nurses' Magazine committee, the Institute had been aware of a need for an official publication, not only to put forward its views but also to meet the constant demand for copies of memoranda on its surveys and research, and for information as to common practice in the district nursing service: in effect, a magazine to meet the needs of the technical and administrative worker in the domiciliary health field.

The Editor discusses format with the Board (from l. to r.) Miss E. Ward (Secretary), Mrs. James Bull, Mr. William Rathbone, The Dowager Lady Rayleigh, Mr. A. H. M. Wedderburn (Chairman), Miss E. J. Merry (General Superintendent), Mr. G. P. Pirie-Gordon, Miss J. R. Anslow (General Secretary).

With the increasing number of enquiries from overseas, it was felt that a publication of this kind would prove a helpful introduction to district nursing and a liaison between the services in this country and abroad.

On 10th April, 1957, after discussions between the parties concerned, and exactly one year prior to the publication of this first issue, the Queen's Institute proposed the taking over of the Queen's Nurses' Magazine with a view to its development as the official journal of the Institute. This proposal met with the approval of the former magazine committee and the Association of Queen's Nurses, and in November 1957, Queen's Nurses' Magazine Limited was registered as a limited liability company. A professional editor was appointed and an editorial committee was set up.

The Institute is anxious to emphasise that this is a journal for all district nurses—hence the title 'District Nursing'—and its aim is to serve all engaged in domiciliary nursing and allied medical, nursing and welfare services, and to help weld these into an integral whole. The Queen's Institute believes that by so doing it will strengthen and further the work of those concerned for the health and welfare of the people of this country and overseas.



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*A
Personal Message
from*

*H.R.H. The Princess Alice
Countess of Athlone
G.C.V.O., G.B.E.*

**Kensington Palace.
Oct. 8.**

As President of the Queen's Institute of
District Nursing, it gives me much pleasure to welcome
the appearance of the official journal of the Institute.

I am sure that it will prove of real value
to those concerned with the public health field, and I
wish it every success.

Alice Mary

To mark the tenth anniversary on 7th April, 1958, of the Constitution of the World Health Organisation
Dr. Hyde, Chairman of the Executive Board 1954-55 looks back at the
accomplishments in health over the past decade

Ten Years of Health Progress

by DR. H. VAN ZILE HYDE

THE ten years just past have demonstrated that man now has at his command the knowledge and the will to eliminate infectious disease from the world. The accomplishment thus far is great; the promise greater.

The story of infectious disease goes back to the beginning of man's life on earth. The bones of children in the earliest graves and the mummies of ancient Egypt testify to the age-old struggle between man and infectious disease. The course of history has often been changed abruptly by mysterious epidemics sweeping over great areas of the earth—the Black Death of the Middle Ages, typhus and influenza in our own times.

Every adult among us has suffered repeatedly from infectious disease and will again. Millions upon millions of persons over the globe are weakened even today by persistent chronic infectious disease.

This is the past and the present, but it need not and will not be the future.

The roots of man's impending triumph over infectious disease reach back a hundred years. Then it was that man learned that most of the diseases with which he was familiar are caused by living organisms so small that they are invisible to the unaided eye.

Quite rapidly then, he developed means for destroying these organisms, through antisepsis; for interrupting their growth and spread, through sanitation; for building internal defences against them, through nutrition and immunization; and for destroying them by medical treatment even after they had infected him.

In those limited areas of the world in which it has been possible to apply this knowledge intensively, much of the burden of infectious disease has now been lifted. In such areas, the public has fully forgotten the terrors of the past—cholera, plague, smallpox and yellow fever.

Parents no longer fear most of the communicable diseases commonly associated with childhood—measles, diphtheria, scarlet fever, whooping cough—because, if they occur at all in these favoured areas, they rarely kill.

Malaria has been eradicated, tuberculosis is fast disappearing, and very recently there has been a major advance against poliomyelitis.

The list of triumphs is a lengthy one. However, the respiratory infections—the common cold, influenza, and pneumonia—are still widely prevalent. There is however growing evidence that these and similar infections that are still widespread will eventually be brought under control. All that may be needed in some cases is more

intensive laboratory research to fill gaps of knowledge already at hand.

Thousands of projects applying modern control methods have been carried out in the jungles, over the deserts, in the great and crowded cities, on every continent and in every country. From this vast experience it has been learned that the available methods can bring about control under conditions found anywhere, if skillfully adapted and energetically utilized.

Disease-carrying insects have been eradicated in the valleys, on the mountains, along the shores; injections of penicillin, vaccinations against smallpox, tuberculosis and other diseases have been given to hundreds of millions of persons, even in the remotest and in the most squalid corners of the earth. This experience has given rise to the expectation of eradication.

The nations of the world are indeed now pledged to work together to bring about the complete eradication of malaria from the earth in the next ten years. It is expected that eradication of other diseases will follow.

This—the extension of knowledge and action from the few to the many—is the significance of the past ten years of health progress. This is the hope and promise that it has brought.

The stage that has been reached thus far in the conquest of infectious disease has not come about by luck but by hard work and effective organization. In the process, hundreds of research centres have been developed; millions of health workers have been trained; hospitals and health centres have been built both in cities and in remote areas; people have formed voluntary organizations to combat sickness through joint action; and governments throughout the world have created national and local health services that increasingly help all people to gain health.

New problems

But the total needs are still very far from being met. Much more growth and extension are urgently needed in order that all may have the degree of protection that is available to an increasing but yet far too small segment of mankind.

Moreover, the mass control of infectious disease does not solve all health problems nor end disease.

As the control of infectious disease advances other problems and diseases take on new importance.

Since infection tends to kill early in life, its widespread control means that more people survive into the older

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age-groups. This creates problems involved in providing employment and care for ever larger numbers of elderly people. It means, too, that the non-infectious diseases that are associated with later years become more common and prominent—heart disease, cancer, diabetes, arteriosclerosis.

Our ability to control infectious disease has been attained in a period of history marked by wide and intensive scientific and technical progress, accompanied by profound social change. New stresses have been created that lead sometimes suddenly and at other times more slowly to disease and premature death. These new and increased stresses take three basic forms—chemical, physical and social.

Development has been so rapid that the true nature and effect of many of these stresses remain thus far a mystery.

Man must now deal increasingly with these problems as he completes his mastery of infectious disease.

The chemical stresses to which we are exposed are legion, and mounting rapidly. Thousands of industrial plants discharge chemical wastes into the rivers and streams that provide our drinking water. Hundreds of chemicals that have not been adequately tested for their effect on man are added to food in order to preserve, colour, and flavour it.

More than 1,000 million pounds of chemical insecticides are used annually in the world in the cultivation of fruits and vegetables, exposing millions of workers to the effects of these chemicals. Some 3,000,000 pounds of gases are discharged into the air of a single large American city each day by motor vehicles and industry.

Chemical miasma

Man takes huge amounts of inorganic chemicals in self-medication. Each year there are produced in one country alone 800,000 pounds of a single sleeping drug and over 60,000 pounds of an awakener, as well as 14,000,000 pounds of aspirin—enough to make 19 billion five-grain tablets.

More recently people who do not appear to be happy either asleep or entirely awake are taking tranquillizing drugs to keep them in between.

How dangerous is this chemical miasma? It is only possible to give partial answers.

There are studies that suggest a possible relationship between minute traces of certain of the metals that occur in food and heart disease and high blood pressure.

Other research suggests that fats in food may be related to these diseases.

More than 300 different chemicals are known to produce cancer in animals. There is evidence that cigarette smoke may contribute to the development of lung cancer in man.

Polluted air has killed people in London and in an American town.

These facts indicate something of the problem in the chemical sphere that emerges as infectious disease recedes.

The physical environment is creating new hazards as industry becomes more concentrated, as greater speeds are attained in the air and on the highways and as new sources of energy develop.

Accidents—particularly automobile accidents—are emerging in many countries as one of the leading causes of death. Rehabilitation of those who have been injured is becoming a major public health activity.

In pace with the technical developments that give rise to increased chemical and physical threats, the social environment is becoming progressively more complex. The machines and institutions created to increase production and facilitate distribution lead to new stresses. The agriculturist—the erstwhile peasant, the farmer, the fellaheen—no longer sustains himself and his family alone in an isolated environment. Today he is increasingly part of an organized community in which he competes and makes his contribution to economic and social progress. He is joining co-operatives, sometimes driving tractors and even in some places automobiles, and educating his children so that they may compete effectively in today's society.

When industry, mechanization and automation are introduced abruptly into a locality changes often come about suddenly, with little time for adaptation. Tradition, customs, taboos, are swept aside unceremoniously by the irresistible assault of progress. Not long ago an airplane made an emergency landing outside a village on a plateau high in the Himalayas. Until that time the villagers had never seen a wheel. One can imagine the shock and strain involved in spanning in one great leap of the imagination and comprehension the full scope of man's millenia of technical development from primitive implements to the airplane!

In this rush of progress man must learn to live with man. The strain is producing its toll. In certain of the highly industrialized countries as many as one half of the total available hospital beds are occupied by persons with mental disease, many of whom are victims of this intense social stress. This provides a crude measure of the scope of the problem.

As we look backwards, we see that over the years man has made great strides in understanding and controlling infectious disease and in building the organization, as well as developing the personnel, that are needed to accomplish world-wide control.

Increasingly, babies are now born to live, not to die. Increasingly, they can expect long life to the full span of three score years and ten. In the past ten years this great new promise has reached out to become a reality to ever more millions of our fellow men.

But we still see as well hundreds upon hundreds of millions of persons unnecessarily sick, millions dying when they need not do so.

The past ten years of health progress have clearly demonstrated that man has in his hands tools that can change the world, bringing to all men new vigour, health and hope. The future is bright, if the tools are used fully and forcefully and everywhere.

The Link to Health

by

GEOFFREY O. BARBER, O.B.E., M.B., B.CH., M.R.C.S.

THE LINK between the general practitioner and the nursing service is a close one, though it could be closer; but the link between the hospital and the general practitioner and the nursing service is tenuous, to put it politely, and non-existent if you like to call a spade a spade. The problem is to get the hospitals to recognise the work that is done for their patients before they come to hospital and after their discharge.

I always believe that personal experience is the thing that matters. Our whole life is directed and coloured by (a) what other people tell us, and (b) what we find out for ourselves. Until we find out for ourselves we tend, of course, to believe what other people tell us.

A Tent and Black Stockings

I remember the first time that I ever saw a district nurse. I was called out by one after I had gone into general practice in Essex. A gipsy woman on one of the greens round Dunmow was having trouble with her baby. It was a November night, and I arrived on the scene with a large torch and in an old car which cost me £32.

I was full of hope and full of the obstetrics that I had learned and been practising at Queen Charlotte's Hospital and St. Mary's Hospital. I was shown a tent on the ground. Poking out from one end of it was a pair of black stockings. That, I was told, was the district nurse.

There was certainly no question of both of us being in this tent together, so out she crawled and in I went, and in due course the baby was born. I realised at that moment and with a sudden impact, that here was something in my scheme of medicine about which I knew nothing, and about which I had better learn as much as I could as quickly as possible. I have been learning ever since.

I soon realised, and have gone on realising ever since, that the district nurses are to us in the villages exactly what the house staff are to the consultants in a hospital. They know what is going on in the village. They know the set-up, the social background, the oecology, of the people in the village very much better than we do, and it is from them that we general practitioners obtain a great deal of information that we do not get from the patients themselves.

It is very often the things that the patients themselves want to gloss over and keep away from the practitioner that are the things which matter, and it is those things,

such as the anxieties and difficulties in the homes of the people, that the district nurses can and do tell us. Therefore in the country villages, where the district nurse is living among the doctor's patients, she is the absolute key-point.

In the country we are rung up by the district nurses and we ring them up ourselves, and we also meet them. There are six district nurses in my neighbourhood and I meet every one of them at least once a week, either because she is in a patient's house when I call there, or because she comes to see me about a case, or I go to see her about a case when I am in the village. Therefore we are working together, not quite so closely as the doctor and nurse in hospital, but very nearly so.

I feel that this happy relationship should be extended, so far as possible, into the towns; but there we come up against a great difficulty. The district nurse in a village or a small town has only a few doctors to deal with. There may be half a dozen, usually in one or two partnerships, but at any rate she knows them all fairly well.

In the towns, on the other hand, the district nurse may cover an area where there are as many as sixty or more general practitioners. How is she going to keep in contact with all of them at the same time? How can she remember that one of them likes a thing done one way, and another likes the same thing done another way, and so on?

Rural Example

She has to use her tact, but, whereas a district nurse may be able to remember the different ways in which six doctors like things done, I do not think that even she could do that in the case of sixty doctors. As I have said, we have a very happy relationship in the country districts, and if that could be carried into the towns it would be of enormous benefit to the doctors, to the nurses and to the patients.

I have already mentioned that as an enquiring medical student and young houseman, I did not know of the existence of district nurses. I feel that this is probably the crux of the matter. The medical student takes an intelligent interest in his work, and in the nursing side of the hospital, but he does not realise that there is any nursing side to general practice until he meets it later on. And he does not realise that general practice in fact differs from hospital life.

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by consultants who have never been outside the hospital. His impact with medicine is entirely concerned with the patient's illness during the time that the patient is in hospital, either as an in-patient or as an out-patient. He knows nothing of what happens during the long period of the patient's life that is spent under the care of the general practitioner, and very often of the district nurse also. He merely knows that sometimes the consultant will screw up his nose and say: "I wish this general practitioner would send me a few more notes about Mrs. Guggenheim's pain in the stomach".

He does not know anything about the careful work of the general practitioner and the district nurse up to the time when the patient comes into hospital. After his operation or treatment in hospital, the patient is discharged and, for all the medical student knows, off he goes into the blue. The patient will in fact go back to the care of the general practitioner and the district nurse, but the medical student knows nothing about the long beginning and possibly the long end: he knows only one circumscribed little middle bit.

That is completely wrong. It is a completely false picture that the medical student is given, and it is one that we are trying so hard to remedy. We are succeeding in our efforts, because medical students are now being sent out, during their time in hospital, before qualification, to general practitioners. This gives them the opportunity of seeing a little of the kind of work that is done by general practitioners, and the treatment which they give to their patients, and the kind of relationship which they have with their patients and the other health services, before and after they go into hospital.

This is where I should like district nurses to push themselves forward, and tell any doctor who has a young student with him that they would like to meet him and

show him what a district nurse is. For our part we are asking doctors who take students to introduce them to the other health services and see that they meet the district nurse, the health visitor, and so on.

In his book, *Good General Practice*, Dr. Stephen Taylor devotes a chapter to the district nurse. As an intelligent man, he realised from his researches that it was the way in which the doctor's treatment was applied to the patients that really mattered, and that it was only through the district nurse that the doctor could be sure that the pills would go in at one end and the other things at the other end. It is the district nurse who really is the key to the application of medicine, whether it comes from the general practitioner or the hospital.

But his reports also showed tremendous variation in practice throughout the county. In one neighbourhood the hospital, the general practitioner and the district nurse were working closely together along the same lines. In an adjoining district there was no contact between them at all, and the general practitioner, hardly conscious of the existence of the district nurse, considered that he could do everything himself and needed no help.

To the district nurses I would say: "Get to know your general practitioners. Push past any little difficulties there may be, particularly with the young ones and sometimes with the old-established ones".

To the general practitioners I would say: "The important thing is to get to know your district nurses".

To the teachers in the hospitals I would say: "Learn something about general practice before you set up to teach young students to be general practitioners. If you start scratching the surface of general practice you will come across the district nurse straight away as an integral part of it".

Next month Miss D. M. Williams, S.R.N., S.C.M., M.T.D., H.V.Cert. (Superintendent, District Nurses' Home, Plymouth), presents the District Nurse's viewpoint

Antibiotics in Influenza

COMMENTING THAT there is as yet no known chemotherapeutic, antibiotic or other drug which specifically influences the clinical effects of influenza viruses, the latest issue of the Ministry of Health's *Prescriber's Notes* points out that the consensus of opinion among family doctors dealing with the Asian epidemic indicates that the uncomplicated cases call for no more than rest, copious fluids and symptomatic treatment with aspirin.

Few doctors feel justified in administering powerful antibiotics to every patient with influenza or, as is not unknown, to every patient with coryza during an influenza epidemic. Such indiscriminate treatment may appear to be a prudent course but neglects the very real dangers of sensitization, toxicity and the propagation of resistant bacteria.

Influenza which requires additional treatment is caused for the most part by secondary bacterial invaders. In the 1957 epidemic treatable complications which most commonly occurred were due to pneumococci, *H. influenzae* and *Staph. aureus*.

Although treatment may differ from doctor to doctor and hospital to hospital, the indications for antibacterial treatment of some sort seem to be fairly clear-cut:

1. Pre-existing chest disease, e.g. chronic bronchitis, bronchiectasis.
2. A history of recent or recurring severe respiratory infections.
3. The presence of heart disease.
4. Evidence of acute pulmonary complications at any stage of the illness.
5. The fulminating case.

Intramuscular penicillin, with or without streptomycin, was favoured in many hospitals and found to be very effective. During epidemics repeated injections can present difficulty in general practice and doctors may be obliged to employ oral therapy. In the presence of the indications listed above a tetracycline would be the drug of choice. Yet because there is no unanimity of medical opinion there are advocates of the use of sulphonamides and various antibiotics of limited range.



The Mount Everest Foundation

Qualities of Leadership

by

SIR JOHN HUNT

WHAT is the test of leadership? I would say that the test lies, like any other commodity or quality, in its endurance. If you look back in history to the personalities of the past, you will have to admit that those were great, from whose standards and examples we still draw inspiration today. Our Lord is the supreme example of enduring leadership. In more modern times I would give you Mahatma Ghandi; he is a lesser, but still great example.

In contrast to these, there are numerous examples of other men and women who roused their contemporaries and whose names have been written in history books, not necessarily in infamy, but who failed to sustain their appeal, both in their time and for posterity.

The really great leader continues to guide the thoughts and actions of men after he has passed on, simply because he enunciated and applied to his own life, some of the eternal truths, something of that essential wisdom which I mentioned earlier.

Now, what are the attributes of a good leader? Unlike the matter of definition, I believe that these are constant for all time. Wavell once asked "Have the conditions so changed as to alter the qualities required of a leader?", and to that I would say "No, nor will they". It is their interpretation which must change with the times.

When we come to look at the qualities of leadership, it seems to me that Vision comes first and foremost. The highest form of leadership can only derive from the vision beyond humanity. That vision may be of a new condition of life for one's fellow men, or it may be some lesser ideal. All great leaders have had some such vision. Cecil Rhodes had it, so did Lincoln, and so did Florence Nightingale. Human beings need this higher guidance. Someone said "Where there is no Vision the people perish".

Next to vision, and closely allied to it, there must be a Purpose, a clear aim crystallised from the vision, towards which every energy is to be directed. In the fighting services we insist on the importance of clearing our minds on the object, or aim, before we make any kind of plan, however trivial. It is a very elementary practice but is a good mental exercise. It helps to rivet in your subconscious the target you are aiming at, so that this colours all your thinking. I only wish one could apply that principle to the ordinary business of living. It is so easy to get involved in ways and means before you are really clear what it is you are trying to do and, even when you have decided what it is you want to do, to know that it is the best thing to do.

To pursue a worth-while aim, inspired by higher vision, implies Integrity. Power corrupts and absolute power corrupts absolutely. How many men have risen to power, respected and trusted by their fellows, filled by high ideals and unselfish motives, and yet become drunk with power, misused it and forgotten their vision. I believe that Napoleon started with fine ideals, even possibly Mussolini and Hitler, and yet all three lost their following and everything they had.

Implicit in integrity is Sincerity. Only if you believe in what you set out to do and have no axe to grind, can you speak with conviction and carry conviction. Sincerity is the hall mark of the uncorrupted man. It shines through his words even though he is no orator; enlightens his whole bearing. John Bright, who admittedly was a remarkable orator, once remarked that true eloquence is but the serious and hearty love of the truth. Another aspect of this quality of sincerity is "being yourself".

Many men who have attained to high places, instead

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confidence . . . preparation . . . knowledge . . . appreciation . . . enthusiasm . . . humility

of allowing their own genius to unfold or accepting their own limitations, seek to be better still by aping other leaders of renown. How many officers I have met in my own Service who have tried to ape the inimitable Monty. We all know the French Military leaders of 1939 who tried to ape their illustrious predecessors of 1914, in what became known as Maginot-mindedness. Churchill said "The success of a great leader doesn't arise from following rules and models laid down by others. There is no surer way to disaster than to imitate plans of bygone heroes and to try to fit them to novel situations". So however mighty in position you may become or even if you acquire but a little power, be yourself: "to thine own self be true".

Now, next I'd put Determination. Once you have decided what you want to do, it is most important not to allow oneself to be deflected from it by any difficulty whatever. It may take years to realise, but provided you continue to be determined about it, and if you have really correctly analysed your aim or its value, you will achieve it in the long run. As an example of single-minded determination I always think of Moses getting his people out of Egypt, and back to their own home country after forty years in the wilderness. You can also think, of course, of the determination of Churchill in 1940.

Determination implies Courage. I am not thinking primarily of physical courage in this context, although this may well have to be manifested in certain conditions of leadership. Moral courage in the face of adversity, hostility from your colleagues and your subordinates, and doubts expressed even by your friends about the course you have taken; that is a far greater thing.

Leaders without Authority

Instances of moral courage which appeal to me are those of the small man with no position and reputation at stake, but with much to lose in security, and comradeship, and his own convenience, who stands up for what his conscience tells him is right, in face of opposition and hard sanctions from his own work mates; the man who has that inner wisdom in industry which I referred to earlier. I needn't quote examples because you know of them. I would say that such men, though they are not in authority, give a lead which all men of integrity must feel moved by. They, too, are leaders.

It is but one step really from courage to Confidence; Confidence in yourself and in those you serve. Confidence in yourself, if it is to survive must derive from that higher vision which I mentioned as the first attribute, and from a correct analysis of your aim. You must be serenely confident if you are to inspire that feeling in others. To appear confident when things are really looking black for your cause, requires moral courage: the two qualities are obviously intertwined.

As an example, I think of Eisenhower on D-day, when everything was poised and ready for the great invasion and everyone was keyed up and trained to the nth degree

and ready to go; when delay would mean a serious set back in morale, probably a leakage in security plans and possibly the making of a new plan. Yet the outlook was black. The weather was very bad, heavy seas and high winds, and all implications of those conditions on the landing of hundreds of thousands of men and thousands of tons of stores on the Normandy beaches. Everything depended on that one man and his demeanour at that moment. One has the picture of Eisenhower, sitting poised in thought and, who knows, in silent prayer, and then firmly and confidently he said "let's go".

But it is not good enough just to have confidence in oneself; you must bestow it on your companions, you must trust them, as you expect them to trust you. Here lies one of the greatest stumbling blocks to good leadership—the ability to decentralise, to share out the work. How much easier it is to do the job yourself, rather than risk it being done less well by other people. But unless you do, unless you do accept that risk, you will have a frustrated and resentful team.

Trust in Opponents

I think one of the finest examples of this trust was given by Abraham Lincoln, who insisted on trusting even his political opponents to the extent of giving them responsible jobs in his government; in the end he won them all over to his side. In any case, unless you do decentralise, you over-burden yourself. A harassed leader is not a good director and he certainly doesn't inspire confidence. We must be free to see the whole picture, to look ahead. So I would say that confidence in both its aspects, is a very important factor.

Just a word about planning ahead, or Preparation. I believe that very few outstanding leaders have not also been hard workers. There is no doubt that there are geniuses who can get away with little work, but if you probe into the secret of most great men's lives, you will find that it is usually founded not on intuition, but on thorough, careful planning and preparation.

Again I think one can look at Churchill whose inspiring eloquence and wisdom have moved the hearts and impelled the actions of millions of people. His influence derived, not from the inspiration of the moment, but from careful forethought and hard work. He once revealed that he never attended any function, even those at which he was not expected to speak, without being absolutely ready to do so. Roosevelt once said that nine-tenths of wisdom is being wise in time.

Moreover, a leader must have knowledge. He won't hold the respect of his colleagues for long, if through the failure to prepare, he reveals that he doesn't know his subject. This acquisition of knowledge has another bearing on the creation of confidence in others. You must share it with them and not regard them as unworthy to receive it. There is no place in this context for "casting your pearls before swine". I think one of Monty's great charms is that he always took his men into his confidence.

He told them what he proposed to do, he made them feel partnered in the job in hand, he flattered their ego.

By contrast, I remember another great fighting chief coming down to the Staff College when I was a student there, and instead of talking to us, he just sat down and said he would take questions. Well, he didn't appreciate us and we certainly didn't appreciate him; he didn't inspire confidence.

I mentioned Flattery, but perhaps that wasn't a very happy word. Appreciation would have been a better one. Leadership is an art, and one of the facets of this art is that of drawing out the best from those with whom you work, both above, alongside, and below you. People like to feel they are playing a useful part, that they have done a job well; so never fail to tell them so, generously.

Some need praise and encouragement more than others, but everyone likes some degree of reassurance from time to time. By the same token curb the temptation to blame. There are some people who need the occasional rebuke, but its often nearer the mark to blame yourself. It is usually some shortcoming in yourself, which is reflected in somebody else's failing.

There remain two other qualities of leadership, which I have left till last, not because I think they are least important, but I wanted to stress them most. By inference you can say that they are the most important of all. The first of these is Enthusiasm. Now there are few qualities more effective than enthusiasm for winning people to action. It spells confidence, conviction and a cheerful disregard of difficulty. It is a quality which I greatly admire, because I so often feel the need for it myself. Give me the man who makes stepping stones out of stumbling blocks, who regards the mountains of life as the mole hills that they so often are. There is no doubt that enthusiasm is most infectious; it is a winning card.

The other last quality is Humility; if that sounds a bit too 'pi', Modesty. I believe that this is the greatest attribute of greatness. It is the proof of integrity; it denotes that sight hasn't been lost of the higher inspira-

CHILDREN'S VILLAGE

THE Pestalozzi Children's Village Trust, which founded at Trogen, Switzerland, in 1946, the first international children's village, is to establish a second village on the same lines on the edge of the village of Sedlescombe, near Battle, Sussex.

The site of 174 acres which has been acquired, includes 130 acres of farmland which will be run as a home farm, both to supply food for the village as well as give initial training to those who want to take up farming as a career.

The Swiss village was established mainly for the benefit of the war-orphans of Europe. That in Britain will cater for needy children not only from Europe, but from the Commonwealth and other parts of the world. The policy of the village is to teach children of all nations and races to live, learn, and play together as a constructive way to the future.

The Trust, which is recognised as a charity, is entirely dependant on voluntary donations. Further details can be obtained from Mrs. Mary Buchanan, Hon. Secretary, Pestalozzi Children's Village Trust, Battle, Sussex.

tion. It is difficult to retain; it is difficult not to take success, the trust and tributes of other people and credit them to your own account. Only if you continue to pass on the credit, to those who work with and for you, and to that higher power, will you retain this essential virtue when you reap the harvest of success.

Humility adds to your stature and increases your power. One of the best examples in modern times is Ghandi. There is one more point about humility, and that is this; only if you retain it, will you be willing to seek and take advice from other people, particularly those below you, to hear their frank opinions and thus add to your own knowledge and wisdom. How many mistakes have been made by leaders who've lost contact with the thoughts of their subordinates, whose pride has caused them to break that vital human link.

So, to sum up, I suggest that these are the qualities of leadership:—

Vision and a clear aim or Purpose; Integrity and Sincerity; Preparation and Knowledge; Determination, Confidence and Courage; Enthusiasm and Humility.

How can they be acquired? Well, I don't doubt that most of you have most of them already and may be some of you have them all. Certainly they are not acquired by one person talking and others listening, or reading about them in books. You can't implant leadership, the plant is there already. We have got it in ourselves, and it is up to us whether we draw it out, train it and cause it to blossom.

Training Ground of Adventure

One of the best training grounds is through one or other form of adventure. Trevelyan wrote of Garibaldi, that "His character was nurtured in the solitude of the sea". He went on to say that no leaders are bred in the cities, but I do think there is no doubt that doing something tough and adventurous, out of the blue, does draw out all the qualities I have been talking about. Best of all, Nature corrects our perspective, restores our sense of values, which are so difficult to discern in the rush and bustle of contemporary life.

So I end where I started. There is a very great need for leaders today; leadership by the many from within rather than a few from above. There is a battle going on for the minds of men, which is being waged with diabolical skill and tireless persistence in every free country. At present it is a one sided war because far too many people remain quite unaware of it, and even those who do, while they are quite clear what they want to resist, are by no means so certain nor of one accord, about the things that are really worth preserving in our way of life.

Only if we create this awareness, reach agreement, clarify our aims and stand together, will we withstand this ideological onslaught, and triumph. So we need men and women of wisdom and faith and courage to give a lead in this task. That is a challenge to all of us.

This article was adapted by permission from an address given by the author at the King George VI Leadership Training Memorial Course

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Basically midwifery is always unchanged but many developments have occurred between the arrival of two sets of triplets cared for by a Queen's Nurse

Domiciliary Midwifery Today

by **ETHEL M. BRYANT**, S.R.N., S.C.M., Q.N. Cert.

IN 1957 triplets were born in a hospital in Exeter, and by the time they were one month old, they came to their own home and to the care of the district midwives.

In 1941 triplets were born in their own home also in Exeter, and were delivered by a Queen's Nurse.

How has domiciliary midwifery changed in these sixteen years?

1941

On the night of the old year of 1941—a night of fog with the country at war, Mrs. Mills was safely delivered by a midwife alone of two girls and a boy, bringing her family up to six children. These babies, weighing 4lbs. each, were kept at home, extra warmth being provided with hot-water bottles—difficult to procure at that time.

They were fed with expressed breast milk at first, and soon all learned to suck and were breast fed until they were over six months old. The babies thrived under the constant care of their mother, and the frequent visits of the nurse for over a year.

At Easter, 1942 they were baptised in our Cathedral—before it was visited by the Nazi bombers. The triplets have now left school, are nearly grown-up, and are three healthy young individuals.

1957

Mrs. Hutton, a primipara who had been married four years, was seen by a consultant obstetrician in the antenatal period because of suspected multiple pregnancy, and triplets were diagnosed. Her arrangements for home confinement were then amended and a hospital booking arranged.

The babies, three girls, were delivered spontaneously after a short labour, their weights being 3 lbs. 13 ozs., 4 lbs. 1 oz. and 2 lbs. 15 ozs. They were resuscitated with oxygen, placed in incubators and later nursed in a premature nursery for their first month. Feeds were at first of expressed breast milk, and subsequently they were all established on National Dried Milk.

At a month old they were discharged

Resuscitated with oxygen and placed in incubators, triplets Susan, Lyn, and Joy have just celebrated their first birthday

from hospital at intervals of a few days, by then feeding well and gaining weight steadily. Arrangements were made for Mrs. Hutton to have a home help several mornings a week, but it soon became evident that her greatest problem was the night care of the babies, who were small enough each to require a 2 a.m. feed.

From our Night Home Help service, which is usually used for old and very ill patients, we were able to supply a help for alternate nights. She arrived at the house at 10 p.m. and stayed until 8 a.m., so relieving the mother for a good night's rest, and giving the babies their feeds at 10 p.m., 2 a.m. and 6 a.m. This was continued until the triplets were four months old and sleeping through the night.

A midwife visited the babies frequently to help the mother with bathing and feeding. They have just had their first birthday, and are three lovely children, of whom their mother is justly proud.

What advantages has the mother from the midwifery services of today?

Mrs. Hutton had free hospital care and the services of a consultant obstetrician. Her children were under the care of a consultant paediatrician and nursed in a special premature nursery until fit for discharge from hospital. Financial assistance was obtainable in the shape of maternity benefit and family allowances. At home, help was provided both by day and by night until the mother

Continued on page 17



Starting a District Nursing Service in

by ROSALIE HUNT

THE Hyacinth Lightbourne Visiting Nursing Service was inaugurated on the 4th February 1957 and already the nurses in their attractive hyacinth blue uniform, with H.L.V.N.S. flash embroidered on their sleeves are well known in Kingston, Jamaica.

A memorial fund was launched early in 1956 to commemorate a brilliant and much loved Medical Officer of Health—Dr. Hyacinth Lightbourne—who was killed in a motor car accident.

The Hyacinth Lightbourne Memorial Advisory Committee was made responsible for this fund and Lady Foot, wife of the Governor of Jamaica, was Chairman.

Soon after the inauguration of this fund, a cheque was received from William Rathbone—great grandson of the William Rathbone of Liverpool who was responsible for the origin of the present system of District Nursing in England.

During the early Summer, Miss N. M. Dixon, Deputy General Superintendent of the Queen's Institute of District Nursing, was on a study tour in Canada. The Jamaica General Trained Nurses' Association, having seen in the Nursing Times the announcement of Miss Dixon's visit, sent a request to the Queen's Institute, that she should visit Jamaica before returning to England, to advise the Hyacinth Lightbourne Memorial Committee on the setting up of a visiting nursing service.

The Queen's Institute agreed to this request and on completion of her visit to New York, Miss Dixon proceeded to Jamaica.



The author, Miss R. Hunt, S.R.N., S.C.M., Q.N. and H.V. certs., was formerly Assistant County Nursing Officer, Dorset

During her short stay in Jamaica, Miss Dixon gave invaluable help and advice to the Memorial Committee and as a result of her visit, it was decided to form the Hyacinth Lightbourne Visiting Nursing Service to begin early in 1957.

As a result of a well attended public meeting at which Miss Dixon was guest speaker, community interest was stimulated and donations immediately promised. Miss Dixon laid emphasis on the need for well trained personnel to start the service.

The Ministry of Health had generously offered to second to the Hyacinth Lightbourne Visiting Nursing Service an experienced Jamaican public health

nurse, Mrs. Thelma DeLeon, to take Queen's training of four months, and an extra six weeks when she would be given special experience in administration and supervision.

I felt very proud and indeed privileged to be asked to come to Jamaica to pioneer this nursing service.

I arrived in Jamaica late at night on the 10th January 1957. Having left London Airport on a cold and foggy January day, it was indeed exciting to wake up to brilliant tropical sunshine. I shall always remember my first Jamaican breakfast—the dining room with a wonderful variety of fruits, exotic flowers and an inviting glimpse of the swimming pool outside.

My first two or three weeks in the island were spent making as many contacts as possible—visiting the hospitals and clinics, talking with doctors and hospital staffs. Members of the Trained Nurses' Association were indefatigable in their help and assistance—arranging meetings and transport.

February 4th 1957 was a great day—the day we decided to begin the practical visiting nursing.

As there was already one Jamaican Queen's Nurse in the island (Miss Elaine Marston), it was decided to start work in two pilot areas, Grant's Pen and Rollington Town. An initial survey was made in the two areas with the help of members of the St. John Ambulance service and with transport provided when possible by the British Red Cross Society (Jamaica Branch).

With our assistants we made house to house contacts publicising the service and inviting membership in the Contributory Scheme, which enabled members for a fee of 12/- per annum to benefit from the service after six months membership. Meanwhile, a fee of 5s. per visit was charged.



Charcoal stoves are a frequent cause of burns. This housewife has her injury dressed by Mrs. DeLeon

ce in Jamaica



Nurse Marston taking the temperature of a sick child

How can I convey to you the thrill and excitement of my first morning on the district here—setting off on this February morning in hot sunshine—proud indeed of my Queen's tropical uniform.

My first patient, an elderly retired Minister of the Church who had had a hemiplegia some months previously—the feeling of apprehension the first few days in case insufficient work came in. What needless fears! Soon we were inundated with requests for our services and our big problem was raising sufficient money to employ another nurse.

We have now (February 1958) four Hyacinth Lightbourne Nurses and myself and for the last three months have done an average of over 1,600 visits each month. We tend to start our day much earlier here, often visiting our first patients before 7 a.m.—the heat later in the day tends to sap one's energy, so we try to get as much work done as possible early in the day.

Our work on the district is similar to that in England regarding the type of case and treatments. Our patients are Jamaican, Syrian, Chinese (a good number), Guianese, Barbadians and Trinidadians.

Housing conditions are very varied, and there is a tremendous amount of extreme poverty. The nurses have to improvise a great deal and adapt their methods to the varying local conditions. Instruments are frequently boiled over small charcoal fires in the yard.

So many of our patients live in one room houses where the only means of cooking is on these small charcoal fires. Usually a number of these one roomed houses are grouped in a yard and the housewives and children

spend most of their time in the yard which is no hardship as practically all the year round, the days are hot and sunny.

The Jamaican children are adorable with their gleaming white teeth and thick curly hair. They soon make friends with their nurse and are eager to show off their skill at dancing—the tiniest children having a wonderful sense of rhythm and soon become expert dancers.

We are proud of our central office which was opened by Mrs. Stow—wife of the acting Governor—in November 1957, and we are delighted to show off our treasured photograph of William Rathbone—generously presented to us by his great grandson who is affectionately known here as William Rathbone II.

On the eve of the end of our first year we were thrilled to hear that H.R.H. Princess Alice had graciously consented to be our patron.

Our problems during the first year have been many but the work has shown steady progress and the service is fulfilling a very great need in the island.

We have been extremely fortunate in our committee, many of whom are senior members of the nursing staffs and active members of the Trained Nurses' Association—all of whom have been unsparing in their help and advice. And how privileged we were to have had first Lady Foot and now Lady Blackburne, as Chairman of our Central Committee.



To enable the district nurses to visit more patients, the gift of a car was made to the service through the efforts of Mr Carlton Alexander

The author is Health Visitor Tutor, Brighton

"More and more I feel it important that the Health Visitor should regard herself as part of the team caring for the family in sickness and in health"

Health Visiting in the Future

by H. H. CONNER, S.R.N., S.C.M., Q.N. & H.V. Certs.

THERE is an old Chinese proverb which says "Study the past if you would divine the future".

So let us make a very rapid survey of the past. Beginning where? The year 1862 I think, because in that year the Ladies' Sanitary Reform Association (later renamed the Manchester and Salford Ladies' Health Society) was formed and it has been recorded that this was the first attempt at 'organised' Health Visiting. The History of Health Visiting is closely bound up with child welfare. In the last century the Infant Mortality Rate was appallingly high. At the end of the century out of every 1,000 babies born alive, approximately 150 died in their first year of life.

Since 1870 education has been compulsory but in those early years few children could benefit because of poor physical and mental condition. In 1892 the first school nurse was appointed and the passing of the Ed.(Admin.Prov.) Act 1907 led to medical inspections—extended to treatment facilities by the Education Act 1921. Notification of tuberculosis was made compulsory in 1912.

I have quoted these three instances because they are the fields in which the Health Visitor is most concerned and they form a good basis for comparison.

'Bonny Babies' the rule

The latest figure of the Infant Mortality Rate available is that of the year 1956 when the rate recorded was 23.8 per 1,000. 'Bonny babies' are now the rule rather than the exception. Today a noticeable improvement in the physical health of school children is seen. Children are taller and heavier than children of earlier years and there is an absence of rickets and other debilitating diseases.

The mortality rates of tuberculosis have fallen considerably in the last fifty years (although an increase in the death rate was noted in the war years) and a patient diagnosed as tuberculous can hope to have active treatment started immediately at home or in hospital.

How have these changes been brought about? Many factors have contributed. Improved environmental conditions—better housing and sanitation. Greater economic security—improved nutrition—legislation which has provided more readily accessible health and welfare services and preventive measures such as vaccination and immunisation, higher educational standards and last, but by no means least—health education and the work of the Health Visitor.

Does this mean then that the Health Visitor has rendered herself unnecessary—is there no longer a need for her services? I do not think so. Much has been accomplished but as old ills have been cured or lessened, new problems have come to light and the Health Visitor, by her experience and training, must still play her part in prevention and alleviation.

The fact that fewer children die today means that there is an increasing number of ageing and aged people in the community, and so a new set of problems arises to be dealt with. Old people without a place in the family circle—suffering from financial hardship perhaps—loneliness, inability or disinclination to meet the needs of daily living, e.g. preparation and cooking of food, maintaining some standard of cleanliness, making and keeping contact with the outside world.

Another feature of modern life is the increasing preoccupation with the material things of life or 'keeping up with the Jones'. This, within reasonable limits, is no doubt commendable but a very far from satisfactory state of affairs has been created when this disrupts family life. It means that more mothers are going out to work and that more children are getting 'second best' care in their own homes because the mother is the homemaker. Children may not suffer so much in the physical sense—in fact they may have more toys and gadgets to play with—but it does mean that many are growing up without direction and discipline, without knowing the real meaning of home life. They are therefore ill prepared to be the 'home makers' of the future.

Much interest has been aroused recently by the Report of the Royal Commission relating to Mental Illness and Mental Deficiency. Interest aroused because it is being brought to our notice more and more—that there is increasing incidence of mental sickness or mental ill health in the community today. Why should this be so? Many theories are put forward—the stresses and strains of modern life—fear of the future—a general feeling of insecurity.

And lastly the 'problem family'. The family so hard to define because factors which create a problem family are so many and varied. The 'problem family' once established may take a lot of time and effort to rehabilitate; therefore it would seem desirable that attention and action should be directed toward PREVENTION.

I hope I have sketched in the pictures of yesterday and today. At the beginning of the century poor housing and environmental conditions—lack of knowledge—and

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Nursing

a generally unsatisfactory state of physical health, especially amongst children. Today—greater knowledge—general security for almost all sections of the community—a physically healthier nation and medical and welfare services available to all. The ills and problems of today are more of the mind and the spirit than the body. So what of Health Visiting of the Future?

I have no gift of second sight. Although so much has been accomplished in the field of physical health, we cannot afford to be complacent. As I have already said the history of health visiting is closely bound up with the maternity and child welfare movement and I think it must still form the basis of the Health Visitor's work. The advent and birth of the baby gains entrance into the home and from that moment the H.V. must think in terms of 'Family Care'. Whilst still concerned with the prevention of ill health I see the emphasis changing to—shall I say—for the want of a better word PREPARATION.

Health Education

The expectant mother prepared physically and mentally for her future role of motherhood. The young child prepared to be a healthy school child and a responsible adult—and the adult prepared to face old age. In a continuous relationship with the family the H.V. can watch the mental as well as the physical well being. Ideally I think the same H.V. should visit, advise and supervise the child from birth to school leaving age. This I feel would help to establish a closer liaison between home and school life and give greater opportunities for health education. Health education will also continue to be one of the main duties of the H.V., talking to groups and taking part in other activities on the larger scale, but we must not lose sight of the fact that health education is also effected in the smaller and more intimate atmosphere of the home. Because of this I feel that the H.V. should be more readily available to those who need help or merely someone to listen to their problems.

Those of us who have done District Nursing and Health Visiting know how confidence can be established and help given when it is possible to "go and ask nurse". The worries spoken of at the time when they are most pressing have a much better chance of being solved. More and more too I feel it is important that the H.V. should regard herself as part of the team caring for the family in *sickness* and in *health*.

I feel very strongly that the phrases 'team work' and 'co-operation' have been used so often and said so glibly that they have ceased to have any real meaning. We should no longer think in terms of 'District Nurse'—'Health Visitor'—or 'Social Worker'—but rather of 'the family'—how 'we' can help them to help themselves to the attainment of healthy, useful lives. I have not used the words 'happy lives' because I feel that is something that must come from within. We cannot hand happiness out on a plate—or a salver—but in our *care* and teaching, help to promote a serenity which will surely bring happiness.

Domiciliary Midwifery Today

Continued from p. 13

was able to care for her babies without this assistance.

Despite the fact that few of these benefits were available to Mrs. Mills in 1941, her babies thrived well and were all breast fed.

What of the work of the midwife in this present day, compared with that of 1941?

She has a better salary, better off-duty, holidays and working conditions. In most cases she has better transport. Her equipment contains a wider range of drugs to use for the patient and in the majority of cases a doctor is booked and available if needed.

The expectant mother of today is encouraged to be more health conscious and has a greater knowledge of her pregnancy and labour. She is able to attend relaxation classes and mothercraft classes to enable her to meet her confinement with more confidence. Her blood is examined during her pregnancy and appropriate action taken when needed.

Services such as the Flying Squad are available to meet an emergency. Advances in medical science have brought the benefits of antibiotics, blood banks, exchange transfusions, milk banks, availability of oxygen, and many other services to make the life of the mother and child safer.

The changes in the nursing care of the mother in the lying-in period have been many, with the stress on early movement, post-natal exercises and early ambulation. It is interesting to recall that early ambulation was first practised during war years to enable mothers to be moved to safety rapidly in the case of air raids.

The baby has less restrictive clothing—back flannels are now a relic of the past and binders are discarded as soon as the umbilicus is healed, or in some places are not even used at all. Feeding is more on demand and less to a rigid time table, with additions introduced into the baby's diet quite early. The need for prophylactic eye drops at birth has ceased, and is no longer a routine in the majority of areas.

Basically, midwifery is always unchanged—that is the care and safety of the mother and child. Reverting to the triplets, a benefit which was granted to both these mothers, but which has now ceased, is that of the Queen's Bounty.

It would be interesting to know of other triplets cared for by Queen's Nurses.

MAY 12 To commemorate Florence Nightingale Day all nurses are asked to wear the emblem of the lamp (not for sale to general public) obtainable from the Hon. Sec., 7 Grosvenor Crescent, London, S.W.1. A minimum donation of 6d. per emblem is suggested. Proceeds support the Florence Nightingale House, London, where nurses from home and overseas can stay whilst taking advanced study courses, the Florence Nightingale International Foundation, and scholarship grants.

A study by a Tuberculosis Visitor, Lincoln, into Norwegian methods of treatment and prevention of tuberculosis

Report from Norway

by JOAN ARCH, S.R.N., S.C.M., Q.N. & H.V. Certs.

ACCOMPANIED by Miss Sybil Luxton, Queen's Nurse, Tuberculosis Visitor, Cornwall, I spent a month in Norway studying the methods of treatment and prevention of tuberculosis.

We were the fortunate recipients of the 1957 R. A. Pilkington Scholarship Awards and set out with high hopes of learning how Norway had achieved such renown in the tuberculosis field.

Our programme was arranged by Miss Frida Lycke, Secretary of the Norwegian Nurses' Association and covered visits to Oslo on the East Coast, Bergen in the West, and Heimdalen in the North. In Oslo we were accommodated at Ullevål Hospital. In Bergen we stayed in an hotel, and followed a comprehensive programme arranged by the Sister-in-Charge of the Lung Department of Haukeland Hospital. Our final week was spent in Ringval Sanatorium. We visited medical and surgical departments for tuberculosis in hospital, health centres to see outdoor control, convalescent homes, training schools and rehabilitation centres.

Norway is roughly one and a half times as large as Great Britain, but the population numbers less than 3½ million. Hundreds of small islands are scattered along the western coast—some with as few as fifteen inhabitants—and to these people the coastal steamers regularly calling from Bergen on a scheduled service are their lifeline.

There are vast, barren mountain wastes, and remote thinly populated valleys which constitute one of Norway's greatest problems—transport. From September to June, some of the main highways and railways may be blocked by snow and telephone communications disrupted.

The fight against tuberculosis began in 1900 when the main Tuberculosis Act was passed making the disease notifiable, and placing the main responsibility of nursing on the public authorities. In this year 9,000 people died from the disease. Proper officials were given power to commit infectious cases to hospital or hold them

in isolation. A patient cannot, however, be forced to remain in hospital against his will.

The present low mortality rates (1.5 for whole country in 1954—all forms of tuberculosis) and other achievements in the tuberculosis field are by no means the result of Government administration alone. Voluntary organisations have played a very great part in building up the health services of the nation. Among the most prominent of these are the Norwegian Women's Public Health Association, and the Norwegian National Tuberculosis and Public Health Association. The latter has the Red Cross of Lorraine as its emblem and nurses who have graduated from its modern training school in Oslo are most commonly seen in sanatoria or other places connected with tuberculosis.

The Norwegian Women's Public Health Association has several training schools for nurses, most of whom after qualifying, work in the tuberculosis field. In 1899, this Association started its campaign against tuberculosis, and a few years later the National Tuberculosis and Public Health Association was founded, and organisation and co-ordination of services to fight the disease began.

Information about the disease was spread to the public by means of lectures and leaflets. All sorts of aid was given to families in distress, and included money, clothing, nourishing food and advice on how to take care of themselves.



Treatment in Ringval sanatorium where the author spent a week, is similar to that in this country

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Sanatoria and homes for the tubercular were built, as were homes for children threatened with tuberculosis. Subsidised houses were made available to raise the living standards of threatened families and summer camps were provided for children. Convalescent homes and vocational training schools were also provided and we visited a convalescent home for men and women which had very recently been taken over by the Women's Public Health Association.

In 1937, the National Tuberculosis and Public Health Association established a B.C.G. Laboratory in Bergen. We visited this laboratory which was taken over by the Government in 1952, and now supplies vaccine for the whole of Norway.

Two Acts of Parliament, passed in 1947, empower local authorities to X-ray and skin test whole groups of the population, if this step is considered necessary. B.C.G. Vaccination may also be enforced.

National Insurance Scheme

Every Norwegian is obliged to belong to the State Insurance Scheme or to other approved schemes. All persons so insured are entitled to medical care until such time as they are able to resume normal duties; each, however, must contribute a small amount to the cost of all doctor's consultations, specialists' fees and drugs. Hospital treatment is provided, half by the State and half by the Insurance Scheme. Private hospitals exist for those who want to use them. Financial aid is also given to patients' dependants. Transport costs to and from treatment are borne by the insurance scheme and patients often have to travel a hundred miles or more.

Bovine tuberculosis was eliminated by means of the Bang method, and tuberculosis in cattle has been unheard of for some years.

Case Finding Methods

At the present time, every effort is being made to prevent the spread of tuberculosis by extending the case finding methods of health centres; mass radiography units visit factories regularly and every section of the community is covered. Mass radiography units on buses and boats visit the rural areas and island communities. It is in the far north that tuberculosis control is most difficult, and here the diet is deficient because of the lack of fresh vegetables.

School children are skin tested during their first year at school and subsequently yearly until they are offered B.C.G. vaccination at the age of 12 or 13 years. Should a converter from negative to positive reaction be discovered, his family is called for screening, skin test and physical examination. Students at evening schools, vocational schools and colleges of all kinds, nurses and student doctors are obliged to have regular skin tests and screening. A nurse is not accepted for training unless she has a positive tuberculin test—produced by B.C.G. if necessary. At one time, the incidence of tuberculosis amongst nurses was considerable, but since B.C.G. and regular control have been introduced very few cases occur.

The armed forces and seamen are given B.C.G., if negative reactors, and all are examined regularly. Teachers and all workers in schools in anyway associated with children are skin tested and screened regularly. Food handlers of all kinds are also subjected to yearly tests.

Control of contacts of all known open cases is rigid and thorough. Examinations are made every two months up to six months and then three monthly up to one year.

Bacterial Control

Dr. Erik Arisholm, Physician in Charge of Ringval Sanatorium, is preparing for publication a paper which will prove the need for making every attempt to isolate the tubercle bacillus, rather than accept unchanged X-rays as proof of inactivity of the disease.

Laryngeal swabs are taken at every examination and if suspicion is felt about any old lesion, bronchoscopy is performed and direct swabs obtained.

One outstanding thing is that there is not a wide diversity of opinion in Norway, either on methods of treatment or control and this was very helpful.

Major thoracic surgery, such as thorocoplasty, is carried out in Oslo whence patients are transported by train or plane from all over the country. Although thorocoplasty originated in Norway, this operation is now being discontinued in favour of lobectomy or resection. Modern experiments have proved that in the latter operations, lung functional capacity is not so greatly reduced.

Patients in Western Norway will shortly be treated in Bergen, where a new lung block with the very latest equipment has recently been opened at Haukeland Hospital.

Artificial pneumothorax is seldom used today; it has always been used with caution and never for long periods. The advent of modern chemotherapy has also reduced the need for this to a certain extent.

Sanatorium treatment is similar to that in this country—we visited two very modern ones. Chemotherapy is not commenced until three days after a patient has been admitted—by this time, six laryngeal swabs at least will have been sent to the laboratory for direct smear and culture tests.

Complete bed rest is ordered for patients with a raised temperature, otherwise they are allowed up for washing. This is not because the value of complete bed rest is not appreciated, but because the Norwegians will not accept it.

Rehabilitation

State and municipally owned rehabilitation centres and training schools exist in most areas, together with those owned by voluntary organisations.

Patients receive pocket money during their training and are found jobs afterwards.

There is a waiting list for admittance for all types of patients and the upper age limit is around 60 years.

Continued on page 21

ON THE HEALTH FRONT

COMMONWEALTH CHEST CONFERENCE

THE Duchess of Kent has promised to open the Commonwealth Chest Conference of the National Association for the Prevention of Tuberculosis, of which she is President.

Thirty-five countries will be sending representatives to the conference which opens at the Royal Festival Hall on Tuesday, 1st July, and will be attended by the Minister of Health.

The programme will include discussions on the prevention of tuberculosis and other chest diseases, including lung cancer, bronchitis, and pneumoconiosis, and the latest clinical developments in treatment. Other sessions will deal with the welfare and rehabilitation of the patient and his family.

Manufacturers of pharmaceutical products, X-ray apparatus, photographic materials, surgical instruments and hospital equipment will be co-operating in an extensive exhibition in the foyer, illustrating the modern drugs and equipment used in the prevention and treatment of chest diseases.

Full details of the conference can be obtained from The Secretary-General, NAPT, Tavistock House North, Tavistock Square, London, W.C.1.

EMOTIONAL STRESS AND ASTHMA

EMOTIONAL stress may precipitate and even be the prime cause of attacks of asthma, declared Dr. G. F. Willson, Oxford's Deputy Medical Officer of Health, at a sessional meeting of the Royal Society of Health on the 28th February. An examination of medical records of over 14,000 children attending local authority schools in Oxford revealed asthma in 239 cases.

Seventeen per cent of these came from homes of unstable relationships, such as strife between parents, strife with in-laws living in the same house, emotional instability of a parent, illegitimacy, absence of a parent, or adoption by unsatisfactory foster parents. Jealousy of attention to a younger child precipitated attacks in several cases. One 6-year-old girl always suffered attacks when she was smacked by her mother, and a two-year-old had his first attack when he lost sight of his mother in a shop.

Although it has frequently been asserted that asthmatic children are above average in intelligence, Dr. Willson's investigations provided no evidence to support the contention.

"Although the initial attacks are distressing in the majority of cases", concluded Dr. Willson, "asthma is a disease which shows a tendency to improve throughout school life. Review of all the asthmatics of school age shows that the number of children whose attacks

have ceased or become trivial outnumber those who still suffer an occasional moderate or severe attack.

"The number of children whose normal activities are being continually hampered by their asthma does not exceed 5 per cent, and in most of these one can hope for a lessening in the severity of the attacks during adolescence. The earlier prophylactic treatment is initiated, the more likely it is to be effective, and results are likely to be best if attention is paid simultaneously to the allergic, ineffective and emotional components."

DEATH AT BIRTH

ALTHOUGH infant mortality has decreased sharply, there has been a much smaller drop in mortality at birth. Since the beginning of the century deaths amongst infants aged six to twelve months, have dropped in England and Wales by 92 per cent, but the decrease in death at birth is only about one third of that.

An initial study of perinatal mortality, covering the period from the twenty-eighth week of pregnancy to the first week of life has therefore been made by the World Health Organisation.

According to the international statistics collected for the study, almost a third of all deaths occur on the day of birth. Conditions of the foetus account for the highest percentage of perinatal mortality, followed by obstetrical causes, congenital malformations, and finally "causes in mother". Many of the deaths in the study, however, are attributed to "ill-defined or unspecified causes", showing that much has yet to be learned about perinatal mortality. The death rate is considerably higher for boys, although far more girls die of congenital malformations of the nervous system.

The general drop in infant mortality has been the result of immunization against communicable diseases, and a decline in gastrointestinal infection due to the education of the mother and the efforts of health and maternity clinics. The scientific knowledge now available makes a further lowering of deaths possible, both from these conditions, and also from those affecting the infant before as well as after birth. For example, syphilis and infectious diseases like German measles and chicken pox, which whilst mild to the expectant mother, can cause congenital defects in the baby. Action to prevent these diseases from damaging the baby must therefore be taken before birth; and in the case of rickets, many years before, if this cause of death of the infant during delivery, is to be checked.

With a qualification on the imperfect nature of the data, as a result of difficulties in collecting statistics in some countries, the study shows Norway with the lowest perinatal mortality, having in 1955, 26 deaths per 1,000

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live births. It is followed by New Zealand, 28; Sweden, 28.4; the Netherlands, 29.2; United States of America, 30.4; Switzerland, 30.9; Canada 31.5; Finland, 33.6; Denmark, 33.9; France, 34; Belgium, 35.4; England and Wales 38.3; Austria, 40.5; Scotland 42.1; German Federal Republic, 44; and Italy, 46.2.

WHEN IS A DRUG A FOOD?

SURPRISE has sometimes been caused to hospital medical staff and their patients when the family doctor announces that an item prescribed in hospital cannot continue to be supplied under the National Health Service on Form E.C.10 because it is regarded as a food and not a drug.

The application of the need for distinctions between a drug and food can, however, cause misunderstandings. One was recently brought to light by the complaint of the paediatricians of a medical school that local practitioners were unwilling to prescribe low calcium milk in idiopathic-hypercalcaemias.

The reason, says the Ministry of Health *Prescriber's Notes*, which are distributed to National Health Service medical practitioners, is that the disease has only been described in recent years and is not therefore specifically mentioned in the First Report of the Definition of Drugs Joint Sub-Committee. Use of low calcium milk in this condition, would however, be covered by paragraph B(i), and may accordingly be prescribed on Form E.C.10.

UNDERPAID PROFESSION

THE County Councils Association is being asked by the Hertfordshire County Council to review the salaries of district nurses and health visitors, who, according to a health committee report, are being paid less than comparable professions.

QUEEN'S NURSES' BROOCH

THE COUNCIL of the Queen's Institute has decided to make available for purchase by all nurses whose names are on the Queen's Roll, a blue enamel and silver replica of the badge of the Institute, to be known as the Queen's Nurses' Brooch. This does not in any way replace the badge of office and may not be worn with Queen's Nurses' uniform; nor does it replace the Long Service Badge awarded after 21 years' service.

The Institute has felt for some time that this brooch would meet the wishes of Queen's Nurses who are not eligible to wear the badge of office for such reasons as working for an authority not connected with the Institute, working abroad, or retirement, etc.

Applications for the Queen's Nurses' Brooch, together with a remittance of £1 10s., should be made to the General Secretary, Queen's Institute of District Nursing, 57 Lower Belgrave Street, London, S.W.1.

An exhibition and sale of needlework by The School of Stitchery and Lace, Bookham, Surrey, the training school for crippled girls, will be held at 28, Portland Place, London, W.1., on Thursday, 24th April, 1958, from 10.30 a.m. to 6.30 p.m.

Report from Norway

Continued from p. 19

Tuberculosis patients are given free choice of training within the boundary of personal physical and mental potentialities.

The Tuberculosis Help Organisation, amongst other forms of help, provides vocational training for tubercular people who make direct application. The training which may be in engineering, carpentry or electrical assembly, takes about ten months and a doctor calls regularly to examine the patients.

On completion of the course, patients are found employment or given financial aid to start their own business.

It is aimed to provide rehabilitation for every needful person in the country, not only for the sake of the mental and physical well being of the person concerned, but in order to use every available pair of hands capable of contributing to the country's resources.

The aim of rehabilitation for tubercular people is to enable them to take their place in society again—not as watch-makers, car park attendants or door-keepers, but as self respecting citizens doing work for which they have an aptitude and liking.

District Nursing

There is no organised district nursing service as in Britain, but in Oslo visits are made by specially trained nurses to the homes of patients discharged from Ullevål Sykehus, who require dressings or other supervision.

Many churches employ nurses to attend the sick in their parishes.

The tuberculosis health visitor performs all skin tests and B.C.G. vaccinations: she works in close co-operation with the chest physician, and arranges her work to suit her own convenience and that of her patients. Uniform is not worn for visiting; late visits are often made to working patients or to patients who may be embarrassed by neighbours observing day-time visits.

Night school students are subjected to yearly skin tests and this entails overtime duties for which the health visitor is paid.

Our only disappointment regarding the tour was that we had no opportunity of visiting patients in their homes. Miss Capjon, Health Visitor in Oslo, did, however, take us to visit a common lodging house where she had a number of patients—her rather more troublesome ones, we gathered—and some were taking their privileged afternoon's rest at the time of our visit.

Voluntary organisations, by their more daring experiments in all fields of health work not only stimulate progress and maintain the pioneering reputation of the country, but also provide scope for the initiative of individuals.

Our month in Norway passed all too quickly, but we saw and learnt much of interest regarding the Norwegian attitude and approach to health problems, and brought back memories of the kindness and generosity of the people.

This Season's Gardens

To compensate for the effects of petrol rationing on last year's proceeds The National Gardens Scheme of the Queen's Institute of District Nursing is making a special effort to achieve a new record result during the coming summer. 1,160 garden owners are generously supporting the Scheme this year, and the photographs reproduced on this page illustrate the wide range of gardens which will be open, from the informal cottage-type of garden full of interesting plants at East Lambrook Manor, to the large and predominantly formal garden at The Lodge, Sandy.

The Queen's Institute's share of the proceeds from the Scheme goes to its Long Service Fund, out of which grants are paid to retired district nurses who were too old to qualify for any of the present-day superannuation schemes. There are many such nurses, some retired and some still working, and the Fund will continue to depend upon substantial contributions from the Gardens Scheme for some years to come.

Copies of the 1958 edition of "The Gardens of England and Wales Open to the Public" can be obtained from The National Gardens Scheme, 57 Lower Belgrave Street, London, S.W.1., price 2/-, plus 6d. postage.

Amateur Gardening Photographs



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Queen's District Nurse Training

IN 1887 the Queen Victoria's Jubilee Institute for Nurses was founded to encourage district nursing throughout the British Isles and to set the standard for the training of district nurses. Florence Nightingale and William Rathbone were responsible for bringing to the Queen's notice the urgent needs in the country for a district nursing service.

The main principles laid down by Florence Nightingale for district nurse training were exceedingly sound and are still modern today. One point she emphasised was that a district nurse must always think of giving total family care when she is called upon to give nursing treatment. She describes this as meaning:

1. A patient to be nursed.
2. A situation to be dealt with.
3. A recurrence to be forestalled.
4. The patient's full restoration to health.

If a district nurse is to be fully prepared for such work she must not only be a State Registered Nurse, but also requires a special training for this work. For many decades the public have valued the skilled help and advice they have received from the district nurse; they expect her to have a wide knowledge of sickness and health, hygiene and the social services, and frequently ask advice on these subjects.

Training Objectives

1. To help the student district nurse develop the right attitude toward patients and their relatives in their own homes.
2. To develop the right approach and relationship to general medical practitioners.
3. To teach the student how to adapt the skills and techniques learned in hospital for use in the district.
4. To show the student how to improvise equipment in such a way that treatment is carried out as efficiently in the home as in hospital.

5. To teach the student the many aspects of district management.

6. To enable the student to teach relatives to carry out instructions between her visits, and show them how they can prevent illness, and help in rehabilitation and a patient's full restoration to health.

7. To help the student accept the responsibilities of her work, with patients' relatives, and with colleagues and other health and social workers.

8. To give the theoretical knowledge that is necessary to enable the student to carry out her responsibilities to the patients and families she serves.

The Queen's district nurse training syllabus covers the details of both practical and theoretical training.

Practical Training

The first month is an introductory period, during which the superintendent is able to assess the student's aptitude for district nursing and the student can decide whether she likes and feels suited to the work. Usually the student's first introduction to district work is given in the district room and class room of the training centre where she is shown demonstrations of the various techniques used on the district, and instructed in care of bags and equipment. The student is then given a gradual introduction to district nursing, first by accompanying a practical nurse teacher who undertakes the nursing care of patients in their own homes. Then the student undertakes the nursing care of a limited number of patients herself, with gradually reduced supervision and guidance by the teacher, learning how to adapt the skills she acquired in hospital to the varied conditions in the patients' homes. She learns how to keep records and is given an introduction to district management. The student is taught the best way to approach the patients—how to assess their needs, how to teach relatives to care for the patients

and the need to co-operate with other health and social workers for the benefit of the patients.

Throughout her training the student is under supervision and she is given teaching and supervisory rounds during her training by the superintendent and her assistants; she also discusses with them the progress and needs of her patients and receives advice and guidance when it is required.

During the training the nurse spends three days in a rural area with a Queen's Nurse undertaking generalised work (i.e. general nursing, midwifery and health visiting) and so gains an insight into the responsibilities of a district nurse working alone.

The theoretical training is begun at the end of the introductory month and may be given either in:

1. A block study period of approximately one month, plus half day study periods each week for the remainder of the training;

or

2. Study days of 1½ days per week throughout the remainder of training.

The curriculum of the theoretical training includes lectures on the history and development of district nursing and all aspects of district nursing management. Lectures are given on special diseases which are often nursed on the district—such as tuberculosis, diabetes, cancer, geriatrics, mental illness and sick children. A specially arranged course of lectures cover the health and social welfare service, environmental hygiene and nutrition. Other subjects covered include the prevention of accidents in the home, health education in the home, occupational therapy and rehabilitation physiotherapy. Special care is given to the principles of posture and lifting for the district nurse.

The Association of Queen's Nurses

UNDER various titles there has been an Association of Queen's Nurses for something like 50 years. As at present constituted the Association was formed by the merger in 1949 of an Association of Queen's Superintendents and the Queen's Nurses' League.

The objects are

- (a) To maintain the highest standards of nursing care and health teaching in the homes of the people;
- (b) To protect and advance the interests and welfare of all Queen's Nurses, particularly in relation to salaries and conditions of service.

The Association of Queen's Nurses is now organised in branches each having a minimum of 20 members. After each central executive committee the honorary secretary of each branch has a memo sent to her setting out the matters which have been forwarded to the central executive committee by other branches, for consideration by all members.

Considerable work has been done on a wide variety of subjects including dangerous drugs left in the homes of the patient; inadequate labelling of lotion bottles; the needs of old people; "Meals on Wheels"; and Darby and Joan Clubs.

The training of the District Nurse, contents of syllabus, and length of training are matters on which members of the Association have made recommendations to the Queen's Institute of District Nursing. Recommendations to the Institute have also been made on long service fund annuities.

The Association has no direct representation on the Whitley Council, but hopes that day will not be distant. It is represented on the Institute Council, Federations, and the editorial committee of "District Nursing".

Largely through the activity of the Association it has been possible to maintain Queen's Nurses on the Council of Royal College of Nursing, and the Central Sectional Committee of the Public Health Section of the Royal College of Nursing. Members of the Association also serve on the General Nursing Council.

In 1948 the first big residential refresher course was organised at Oxford. 103 Queen's Nurses attended, each paying their own expenses. The Queen's Institute generously co-operated and Miss E. J. Merry, then education officer, organised the syllabus.

These refresher courses became an annual event, recognised by the Ministry of Health, and in 1953 the work was handed over to the Institute's education department.

The Association is in membership with The National Council of Nurses of Gt. Britain and Northern Ireland, and through them to the International Council of Nurses, the oldest international association of professional women. It was founded in 1899 by an Englishwoman—Mrs. Bedford Fenwick.

Each year the Association organises conferences of their members, usually during the same week-end as the annual meeting. This gives many members an opportunity not only for free discussion of problems but meeting colleagues from all over the country. The annual dinner of the Association is always very popular with members. These are not always held in London, but in places as far apart as Cardiff and Sunderland.

The Association's vitality is very evident at the meetings of the central executive committee with representatives from each branch—two administrators, and two Queen's nursing sisters or Queen's male nurses, who at one meeting may have before them as many as ten resolutions from the branches that operate throughout the country.

The subscription of £1 0 0 per annum covers the fares of the representatives from the branches, affiliation fee to the National Council of Nurses, and cost of rooms for conferences, annual meeting, etc.

The Constitution states that the President shall be the General Superintendent for the time being of the Queen's Institute of District Nursing. Therein is the great link between members of the Association and the Queen's Institute.

E.I.

South Western Federation

AT A MEETING of the South Western Federation of Members of the Queen's Institute of District Nursing in Bristol in February, Mrs. A. Robb criticised the allowance of £30 by the Exeter District Nursing Association for the provision of District Nurses' uniform. Members of other authorities agreed that the amount was inadequate; and it was pointed out that all other authorities within the Federation area met the full cost of uniform.

It was also reported that the Gloucestershire County Nursing Association had agreed to pay with effect from 1st April, 1958, a laundry allowance of 5s. 0d. per week to its nursing staff, and also to pay accounts in respect of midwifery gowns, and bag linings.

The Lady Victoria Forester was re-elected chairman of the Federation, and Mr. A. E. Wills elected vice-chairman. Dr. G. F. Bramley and Mr. A. F. Poyser were re-appointed honorary secretary, and honorary treasurer respectively.

Queen's Nurses Personnel changes 1st to 28th February, 1958

APPOINTMENTS

Superintendents, etc.

Falconer, Mary G., County Antrim (Assistant County Superintendent)
Keeler, Sara, Worcestershire (Chief Nursing Officer)
Thistlethwaite, Mary, Manchester, (Hulme & Moss Side) (Superintendent).

Nurses

Beckett, Mildred (Mrs.), Liverpool.
Beech, Audrey (Mrs.), Liverpool.
Bell, Frederick, Lincoln City.
Butler, Olive (Mrs.), Buckinghamshire.
Chisholm, Jean R., West Riding, Yorkshire.
Cordiner, Barbara, County Antrim.
Davidson, Edythe, Leicestershire.
Durley, Ivy C., Hampshire.
Fuller, Daisy L. (Mrs.), Norfolk.
Goodison, Millicent, Lancashire (Div. 2).
Greggs, Mary M., Gloucestershire.
Hare, Gladys (Mrs.), Cambridgeshire.
Harrington, Ethnea P., Norfolk.
Hawes, Mary, Liverpool.
Hulks, Ruth P., Kilburn & West Hampstead.
Humphrey, Margaret (Mrs.), Nottingham City.
Inglefield, Hazel M., East London.
Jamieson, Elizabeth (Mrs.), Liverpool.
Kelly, Kathleen M., Kent.
Knowles, Elsie, Huddersfield.
Phillips, Joan, Surrey.
Potter, Elizabeth, County Antrim.
Rendell, Dolly May, Blackburn.
Richards, Lilian A., Norfolk.
Scammell, Joyce (Mrs.), Surrey.
Sutton, Marjorie (Mrs.), Hampshire.

Trevethick, A. B. (Mrs.), Lancashire (Div. 15).

Warren, Margaret, West Sussex.
White, Phyllis Mary, Lancashire.
Winder, Helen M., Hampshire.

RESIGNATIONS

Baldwin, Greta, Kent—Domestic reasons.
Barton, Olive (Mrs.), Stockport—Health reasons.
Brabrook, Kathleen, Hampshire—Post in Hospital.
Brockway, Vera, Gloucestershire—Health reasons.
Brown, Mary, Oxford—Health reasons.
Butcher, Ivy, Middlesex—Personal reasons.
Byrne, Catherine, Kensington—Domestic reasons.
Caffrey, Bridget, Westminster & Chelsea—End of contract.
Cogan, Mary, West Riding, Yorkshire—Retirement.
Collier, Elizabeth, Lancashire—Post as full-time Midwife.
Connaughton, Joan, Croydon—Marriage.
Culverhouse, Lilian, Cornwall, Retirement.
Delahunty, Anna, Hampshire—Personal reasons.
Earle, Joyce, Norfolk—Retirement.
Ellis, Joan, Brixton—To go to Canada.
Goodwin, Vera, Hertfordshire—To work nearer home.
Gowen, Kathleen, Gloucestershire—Domestic reasons.
Greene, Hazel (Mrs.), Hertfordshire—Domestic reasons.
Gwilliam, Rosamund, Gloucestershire—Post in hospital.

Hall, N. G., Kent—Retirement.
Hodgkinson, Elizabeth, Lancashire—Retirement.
King, Mairola, Cardiff—Domestic reasons.
Lawton, Jessie, Dorset—Retirement.
McNamara, Bridget, Gloucestershire—Health reasons.
Parsons, Nora, Gloucestershire—Health reasons.
Pearce, Joyce, Gloucestershire—Health reasons.
Pilkington, Barbara, Lancashire—Domestic reasons.
Price, Margaret, Cornwall—Marriage.
Southgate, Marjorie, Essex—To work nearer home.
Taylor, Janet C., Liverpool—Domestic reasons.
Ward, Margaret, Hertfordshire—Emigrating to Rhodesia.
Wyse, Helen, Gloucestershire—Personal reasons.

Scottish Branch

APPOINTMENTS

Superintendents, Assistant Superintendents, etc.

Milne, S. W. C., Glasgow (Annie'sland) Superintendent.
Shearer, C. K. T., Berwickshire—Superintendent.

Nurses

Arbuckle, S., Waterbeek.
Armour, L., Perth.
Bain, A., Methil.
Butler, J. M. M., Dalmellington.
Hiddleston, J. B., Stranraer.
Jaffrey, E. C., Lochbarbriggs.
MacGruer, M. M., Lossiemouth.
MacLeod, M. A., Garyvard.
MacNaughton, E., Crieff.
Matthew, K., Hawick (Temp.).
Ross, J. N., Lerwick.
Semple, C. H., St. Martins.
Wemyss, Patricia, Cardenden.
Wemyss, Rose, Ayrshire.
Whitcott, I. M. R., Ayrshire.

RESIGNATIONS

Barr, Isobel Loch, Monkton—Other work.
Campbell, Torquilena M., Clydebank—Work abroad.
Carnochan, Mary Stewart, Glasgow (Dennistoun)—Marriage.
Gargan, Susan Ann, Glasgow—Other work.
Joiner, Annie, Kilmallie—Marriage.
Kinnear, Renne May, Perth—Other work.
MacSween, Marion, Midlothian—Marriage.
McKinnon, Chrissie, Kilmarnock—Home reasons.
Moore, Mary Geraldine, Glasgow (Dennistoun)—Other work.
Murray, Mary Findlay, Kildalton—Marriage.
O'Regan, Teresa Margt, Edinburgh—Through marriage.
Priest, Mrs. Annie O. W., Edinburgh—Through marriage.
Sorley, Margt. Isabella, Ardtornish—Marriage.
Taylor, Elizabeth Marion, Balfour—Other work.
Whelan, Margt. Cook, Dundee—Work abroad.

The Association of Queen's Nurses

President: Miss E. J. Merry

Hon. Secretary: Miss Fairless, 46 Wembley Road, Mossley Hill, Liverpool, 18

Hon. Treasurer: Miss Ryding, 130 Dentons Green Lane, St. Helens, Lancashire

The Annual Meeting of the Association is being held on Saturday, May 17th 1958 at 2.30 p.m. in The Great Hall, Royal College of Surgeons, Lincolns Inn Fields, London, W.C.2.

Each Branch has two official delegates, one an Administrator and one a Queen's Nursing Sister or Queen's Male Nurse, and they alone have voting powers on behalf of their Branch. This meeting will be followed by the Presentation to Miss E. J. Merry, President of the Association, and General Superintendent of the Queen's Institute of District Nursing.

All who wish to be associated with this presentation should send their personal gift and make application for a ticket for tea, to Miss A. M. Englefield, 75 Wood Vale, Muswell Hill, London, N.10., not later than May 1st 1958.

A Conference of members is being held in London on Monday, May 19th 1958. This is open to ALL members of the Association who have paid their current subscription. Items for discussion to be included on the Agenda should be sent to Miss Fairless, Hon. Secretary, 46 Wembley Road, Mossley Hill, Liverpool 18 at the earliest possible moment. Members sending in items for the Agenda must be prepared to open the discussion.

Queen's Roll Examination Pass List

The following have been enrolled as Queen's Nurses from 1st March, 1958

Birmingham

Carpenter, Jean Vivienne
Dowd, Annie
Egan, Doreen Winifred
Finn, Eva Laura
Heard, Sheila
Hunt, Winifred Elsie
Frain, Doreen Clara

Blackburn

Robinson, John
Smith, Margaret

Bolton

Rychtr, Miloslav

Bradford

Griffiths, Nellie Beatrice
Holcroft, Branka Terezija
Jordan, John Herbert
Wain, Frances Kathleen

Brighton

Ashbridge, Helen Catherine
Cresswell, Shirley Alice
Penny, Doris Maud
Roberts, Grace Margaret
Smith, Olive

Bristol

Clinton, Maureen Teresa
Griffiths, Edith Moreen
Maskell, Kathleen Margaret
Oakford, Ruth
Riddell, Elisabeth Margaret
Sellick, Frances Caroline
Sweet, Pamela Isabel

Brixton

Rose, Doreen Adauphney

Bury

Revitt, Margaret
Weathered, Brenda

Camberwell

Brunsdon, Enid May
Groves, Mary
Hicks, Virginia Alice

East London

Beckett, Albert
Taylor, Prudence Anne
Tobias, Barbara

Essex County

Bower, Barbara Ruth
Brigden, Valeria Gertrude
Brown, Betty Norah
Butler, Henry Jack
Catherall, Nancy Phyllis
Day, Patricia Evelyn Phyllis
East, Anne Margaret
Ellis, Elin Oliver
Flynn, Nora Mary
Fredman, Ray Isabel
Green, Alan
Greene, Margaret
Harvey, Peter Fred
Lawrence, Carmen Rubertha
Massey, Patricia Ada
Pearce, Sylvia Joan
Seabrook, Joy Dorothy
Taylor, Dorothy
Willett, Eileen Mavis

Exeter

Atkins, Sheila Mary
Stirk, Kathleen Hunter
Wickens, Jean Mary

Gloucester

McLean, Isa Mary
Rees, Patricia Rose
Sage, Dorothy Jannice
Tearne, Margaret Evelyn

Guildford

Kassam, Gulshan
Philp, Anne
Tullett, Gwendoline Anne
Westwood, Gertrude Sydney

Hackney

Harvey, Norma Jean
Hope, Margaret
White, Eilda

Halifax

Bedford, Betty
Broadbent, Patricia Mary
Fleming, Kathleen Nora
Smelt, Derek

Huddersfield

Burtoft, Beatrice
Lee, Martha Louise

Kensington

Dean, Winifred Edith
Williams-Ugah, Grace

Lancashire

Ashurst, Alice
Denny, Mary Elizabeth
Fahy, Mary Angela
Fairhurst, Alice
Hamer, Elsie
Knipe, Jean Margaret
McBride, Margaret
O'Donnell, Honor
Webster, Doris

Leeds

Baines, Brenda Mary
Booker, Stella
Borthwick, Jean Huie
Chappell, Maureen
Mason, Barbara Ann
Sharp, Muriel
Sutcliffe, Dorothy Amy

Leicester

Lowe, Ellen
Parker, Gwen
Pebody, Mary
Smith, Frances Muriel Patricia

Liverpool

Bartels, Maria Gerarda Elisa
Carter, Bridget
Gardner, Muriel May
Hilliard, Doris
Jones, Doreen Olwen
Jones, Sydney Lloyd
Menarry, Adrienne
O'Connor, Julia Cecilia
Willatt, Dorothy

Manchester (Ardwick)

Aumonier, Margaret Evelyn
Ward, Mary Kate

Manchester (Harpurhey)

Germain, Marjorie Isabel
Higgins, Francis

Metropolitan

Comish, Olive
Griffith, Mair Bryn
Morgan, Lenaura
Nolan, Elizabeth Carmel
Rutherford, Margaret
Thomas, Mair

Middlesborough

Alderson, Edith Rose Mary
Murray, June
Thompson, George William

North London

Ross, Emily

Nottingham

Finn, Margaret Marion
Lane, Mary Collishaw
Radford, Peggy
Smyth, Mary
Turner, Joan Barbara

Oxford

Oakley, Sara Elizabeth
Till, Joan Margaret
Turner, Thelma Gladys

Paddington & St. Marylebone

Boy, Pamela
McCatty, Mavis Isadore

Plymouth

Montgomery, Isobel May
Motzkus, May Ethel

Portsmouth (Hilsea)

Luxton, Joan Teresa
Smee, Patricia Anne

Portsmouth (Southsea)

Morris, Elizabeth Eileen
Orwin, Marjorie Mary

Reading

Harris, Greta June
Roberts, Florence Mary

Rotherham

Coates, Inge
Lambert, Gloria Margaret
Martin, Joyce

St. Helens

Hayes, Mary Bridget

St. Olave's

Robertson, Cynthia

Salford

Barnett, Doris

Sheffield (Johnson Memorial House)

Brennan, Mary
Palmer, Beryl

Sheffield (Princess Mary Home)

Trimble, Harriet May

Stockport

Hamilton, Ann
Rodgers, Gladys
Town, Dorothy

Sunderland

Lackenby, Irene Elizabeth

Surbiton

Gittens, Mintrude Bridget
Lord, Gwendoline Mary
Newton, Mary Veronica
Silverson, Queenie Myrtle

Warrington

Brown, Brenda Winifred
Maher, Winifred Dorothy

Watford

Ridgers, Dora
Rowan, Jean Mary

Westminster & Chelsea

Glendinning, Mary Ann
Goodwin, Esme

Middx. C.C. (Willesden)

Andrews, Gertrude Elizabeth
Foster, Doreen Lydia Annie
Serry, Heather

Woolwich & Plumstead

Werner, Aurelie

Worcester

Davies, Edna Frances
Hicking, Coral Antoinette
King, Roy Trevor
Lawrence, Gwenda Mary
Walker, Rachel

Aberdeen

Campbell, Christina
Emslie, Lorna
Ferguson, Mary Anne
Salter, Henzel Annie Jean
West, Norma

Edinburgh

Allan, Elizabeth Mary
Armstrong, Sarah
Boa, Christina
Brash, Margaret Jane
Brown, Jean Russell Gibson
Dennahey, Jane Helen Hamilton
McIntosh
Duncan, Dorothy
Fairweather, Marjory Marshall
Fergusson, Irene Mary
Groat, John
Hiddleston, Jane Brown
Houston, Isabell
Knight, Mary Cairns
Macdonald, Catherine
MacDonald, Christina
Mackenzie, Iona
Ormerod, Mary Elizabeth
Quinn, James Edward
Ross, Jane Netta
Ross, Mary
Rowbottom, Ada Isabella
Stoddart, Elizabeth Mary
Wemyss, Rose
Whitcott, Irene Rosalie Maud
Wood, Marion Thomson Lindsay

Glasgow

Campbell, Annie
Campbell, Margaret
Carlin, Martha
Dickie, Sarah Margaret Mills
Gargan, Susan Ann
Gray, Isabel Betty
Kerr, Barbara
McClure, Marguerite
McWilliam, Catherine Mary

Belfast

Braniff, Annie
Harvey, Margaret
Hunter, Phyllis Elizabeth
Sirr, Anna Kathleen
Tracey, Eileen Mary Theresa

Dublin

Clarke, Mary Teresa
Greene, Kate

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APPEALS

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Further particulars may be obtained from the Education Officer, Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

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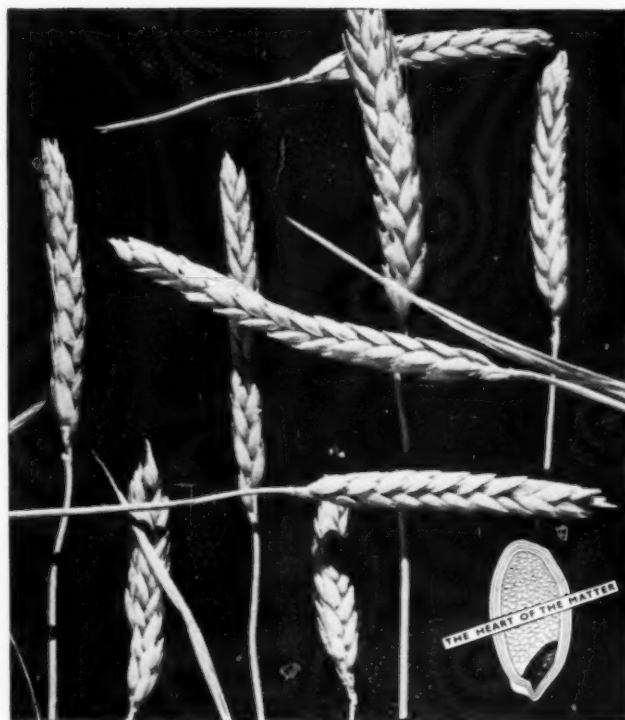
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Particulars, and information about bursaries available, may be obtained from:—

- (1) The Education Department, Q.I.D.N., 57, Lower Belgrave Street, London, S.W.1.
- (2) The Organising Tutor, Bolton Technical College, Manchester Road, Bolton.
- (3) The Organising Tutor, Arts & Social Studies Dept., Brighton Technical College, 251, Preston Road, Brighton.

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